MINUTES OF THE BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES, STATE OF CALIFORNIA

Violet Varona-Lukens, Executive Officer-
Clerk of the Board of Supervisors
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Director of Health Services

At its meeting held January 13, 2004, the Board took the following action:

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By common consent, and there being no objection, the Board continued to January 27, 2004 at 11:30 a.m. the Health Department Budget Committee of the Whole/Joint meeting of the Board of Supervisors relating to the status report by the Director of Heath Services on Scenario III of the Department's system redesign plan.

Later in the meeting, Dr. Thomas L. Garthwaite, Director of Health Services reported on the status of management oversight activities at King/Drew Medical Center and the restructuring of its graduate medical education programs, as detailed in his attached memorandum dated January 9, 2004. Dr. David Satcher, Chair of the Task Force on Graduate Medical Education at King/Drew Medical Center, made verbal presentation regarding the attached findings and recommendations of the Task Force on Graduate Medical Education.

Janice Hahn, Councilmember of the City of Los Angeles, Dr. Roberta Bruni, Dr. Kamili, Dr. Ike, Dr. Gerald Levy, Winston E. Spell, Genevieve Clavreul, Nelle W. Ivory and Tim Watkins addressed the Board.

After discussion, Supervisor Yaroslavsky made a motion that the Board approve the recommendations contained in the Director of Health Services January 9, 2004 memorandum with an amendment to Recommendation No. 1 as noted:

> Authorize the Director of Health Services to notify Drew University of the County's intent to terminate the affiliation agreement effective September 1, 2004 and renegotiate the terms and conditions of the affiliation agreement for Board consideration prior to September 1, 2004; and instruct the Director of Health Services while renegotiating an affiliation agreement with Drew University to establish a parallel planning track that would enable the Department to maintain hospital services at the King/Drew Medical Center, should negotiations with Drew University prove unsuccessful;

(Continued on Page 2)

After further discussion, Supervisor Yaroslavsky requested after introducing his amendment that it be continued to the meeting of March 9, 2004.

Therefore on motion of Supervisor Yaroslavsky, seconded by Supervisor Antonovich, unanimously carried, the Board ordered placed on the March 9, 2004 agenda Supervisor Yaroslavsky's recommendation to instruct the Director of Health Services while negotiating the affiliation agreement with Drew University to establish a parallel planning track that would enable the Department to maintain hospital services at the King/Drew Medical Center, should the affiliation agreement negotiations with Drew University prove unsuccessful.

After further discussion, on motion of Supervisor Yaroslavsky, seconded by Supervisor Antonovich, unanimously carried, the Board took the following actions:

1. Authorized the Director of Health Services to notify Drew University of the County's intent to terminate the affiliation agreement effective September 1, 2004 and to renegotiate the terms and conditions of the affiliation agreement for Board consideration prior to September 1, 2004;

2. Authorized the Director of Health Services to take the necessary administrative steps to facilitate the consolidation or restructuring of clinical services at King/Drew Medical Center; and

3. Delegated authority to the Director of Health Services to amend the current agreements with nurse registry agencies to establish rates that are consistent with those paid in the community for critical care, clinic, emergency room, surgical technologists, and hemodialysis nurses and nursing attendants, and to negotiate and execute agreements with any additional nurse registries that are willing to agree to the County's terms and conditions.

Further, the Board agreed to conduct a hearing in the surrounding community regarding Martin Luther King/Drew Medical Center, and instructed the Director of Health Services to coordinate an appropriate hearing date.

Attachments

01011304-S-2

Copies distributed:
Each Supervisor
Chief Administrative Officer
County Counsel

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

January 9, 2004

TO: Each Supervisor

FROM: Thomas L. Garthwaite, MD
Director and Chief Medical Officer

SUBJECT: KING/DREW MEDICAL CENTER

At the January 6, 2004, meeting of your Board, you requested that the Department of Health Services (DHS) provide its recommendations regarding the management of King/Drew Medical Center and the restructuring of its graduate medical education programs.

As you know, the Department has taken escalating steps to review and restructure the operational, clinical, and academic management of King/Drew Medical Center. The hospital's leadership – both operationally and clinically – has failed to establish the necessary management and communication systems to enable the facility to properly manage the delivery of services. These system failures are historic and deep and include such things as the lack of human resources processes, the absence of effective communication among managers and to staff, and a failure to implement quality assurance activities. These factors have contributed to a culture that fails to hold employees accountable for their actions and as such ultimately fails the patients and community it serves.

While the management of the hospital poses a significant challenge, these issues were not identified by the Accreditation Council on Graduate Medical Education (ACGME) as the primary reason for the loss of accreditation of the surgery and radiology programs. Rather, the ACGME's primary concern was the academic environment in which the residents were received their education and training.

The Task Force on Graduate Medical Education at King/Drew Medical Center cited similar concerns in the report it released in December. The Task Force, which was chaired by former Surgeon General David Satcher, identified substantial leadership and accountability issues at Charles R. Drew University of Medicine and Science (Drew University) and recommended a number of significant changes in the organization and scope of the training programs the University supervises at the hospital.

Correcting the problems that have accumulated at King/Drew Medical Center and Drew University will require major changes, some of which will be made swiftly and smoothly and others that will be much more difficult to achieve. In the past three months, we have replaced the leadership at King/Drew Medical Center and have made significant strides in identifying problems and fixing them. More recently, Drew has taken steps to change its leadership. While these changes are necessary and important in the short term, they will not be sufficient to effect long term change. Long term effects will require bold structural changes.

Recommended Structural Changes

1. *Operations*

   The Department has made significant changes in the operation of King/Drew Medical Center over the past three months. It is our intention to continue to conduct a complete review of all aspects of the hospital, from the direct provision of clinical services to the management of housekeeping. Some of the changes at King/Drew Medical Center will require the reorganization of both clinical and support/administrative services at the hospital, including the potential consolidation of services with other facilities. To this end, the Department is requesting authority from your Board to take the necessary administrative steps to facilitate the restructuring of services at King/Drew Medical Center and the consolidation of services system-wide.

2. *Efficiency Savings*

   The Department's strategic plan included 16 percent in savings at King/Drew Medical Center over the period of Fiscal Year 2003-04 to 2005-06. While the Department believes these savings are achievable, given the dramatic nature of the changes that must occur at the hospital and the medical school and to avoid destabilizing the environment, the period of time during which these reductions will occur may be extended. I plan to update your Board on this topic when the Department updates its budget forecast.

3. *Flexibility in Hiring Nurses*

Evaluations by DHS staff, as well as recent site visits by State Licensing, have highlighted the crucial need for enhanced nurse recruitment and training at King/Drew Medical Center. While all DHS hospitals are challenged to hire critical care nurses, this problem is most acute at King/Drew Medical Center, particularly given the recent problems with the staffing of the hospital's telemetry unit. While the Department's first priority is to hire full-time permanent nursing personnel, this is not always possible. To facilitate the reopening of the telemetry unit and ensure patient safety, DHS has attempted to secure additional nursing personnel through registries. The rates included in the current registry agreements are substantially below the market rate and, thus nursing registries are unable to accommodate the Department's requests, given the competition for these and other types of critically needed nursing services.

The Department is requesting delegated authority to amend the current agreements with nurse registries to establish rates that are consistent with those paid in the community for critical care, clinic, emergency room, and hemodialysis nurses, nursing attendants, and surgical technologists, and to negotiate and execute agreements with any additional nurse registries that are willing to agree to the County's terms and conditions. DHS will notify your Board as to the progress of these negotiations and of any specific rates that have been agreed upon.

4. *Graduate Medical Education Programs*

The withdrawal by the ACGME of the accreditation of the surgery and radiology training programs, and the proposed withdrawal of the neonatal-perinatal program have brought to light the need for a reevaluation and restructuring of the Department's partnership with Drew University. As mentioned above, the recommendations for the Task Force on Graduate Medical Education at King/Drew Medical Center focused primarily on the role of Drew University; but clearly, given its historical and contractual relationship with the medical school, the Department must play a critical part in any improvements that occur.

The pace of reforms at Drew University, like those at the hospital, cannot be slow and incremental, but must be immediate and dramatic. Specifically, we must assure full reconfiguration of the Board of Trustees, a realistic number of residency programs and the development and implementation of an acceptable faculty practice plan or other mechanism to reward clinical work and teaching. To

that end, the Department will be notifying Drew University of its intent to terminate the existing agreement and replace it with a contract that reflects necessary changes in the relationship and expectations of the University. I expect that renegotiation of the affiliation agreement would be completed by no later than September 1, 2004.

The Department intends to work with Drew University to evaluate each residency program. In some cases, it may be proposed that a program be eliminated altogether and in other cases, that a program be combined with other County programs. While the option of combining with other County programs will be aggressively pursued, I am sensitive to the need to assure that the educational experience at King/Drew Medical Center will be of the highest quality.

The Department will report back by the end of February with a long-term plan for the organization and management of residency programs at King/Drew Medical Center.

5. *Role of Other Universities*

There are some immediate steps that must occur, in which the participation of another medical school, such as UCLA or USC, would be of great value. The first of these is in the review of the existing training programs at King/Drew Medical Center. The Task Force on Graduate Medical Education's report noted that the size of the hospital does not support the number of training programs or residents that currently exist. We agree that this is an important step that must occur. A reduction in the number of programs to those that support the core clinical and educational missions of King/Drew Medical Center will allow both the hospital and the medical school to focus their efforts and allow for the development or reconfiguration of residency programs that better address the specific health care needs of the community. Both UCLA and USC have a wealth of expertise that can contribute to the assessment of each of the existing programs at King/Drew Medical Center and assist in the development of a plan to reduce the size and scope of training programs at this facility.

The Task Force on Graduate Medical Education envisions a center of excellence in multicultural health care and public health at King/Drew Medical Center. If such a center of excellence can be developed, opportunities for collaboration with UCLA and USC in research, training, and clinical care might naturally emerge.

6. *Affiliation Agreement Oversight and Management*

The issues with Drew University bring to light the need to enhance the oversight and management of the medical school affiliation agreements. In recognition of this, I am creating a new position of Senior Medical Director for Clinical Affairs and Affiliations. This individual will be responsible for responsible for developing and directing Department of Health Services (DHS) policy related to the management of clinical activities. The responsibilities of this individual would include:

- Providing oversight to the development and management of the medical school affiliation agreements.
- Overseeing DHS Graduate Medical Education programs, including the standardization, consolidation, and collaboration of DHS training programs, as well as supervising the operation of medical education programs in DHS facilities to ensure compliance with ACGME accreditation standards and continued full accreditation of programs by the respective ACGME Residency Review Committees.
- Directing the establishment and implementation of physician policy matters, such as clinical performance measures.
- Directing DHS policy regarding clinical research and supervise establishment and implementation of DHS research protocols and chairing the DHS Research Oversight Committee/System-wide Institutional Review Board.

The Department is working with the Chief Administrative Office and Department of Human Resources to establish this new position.

7. *New Personnel System*

The civil service system is poorly designed for health care operations. It is slow to respond to new job titles and competencies, fails to recognize the multiple shifts necessary in the hospital, and does not keep pace with market fluctuations in salaries. Governments that run health care institutions have also found it hard to pay a competitive salary to physician subspecialists - although they end up paying the same amounts via contract or other mechanism. The Federal Government recognized these problems in using the general civil service in health care in 1946 when it established Title 38. This separate Title allows 12 clinical professions to be paid separately from other government workers. In 1986, the use of this

separate personnel system was expanded to include the Clinical Center at the National Institutes of Health and other Federal clinicians.

Your Board approved DHS' development of a similar system in approved the June 2002 System Redesign Plan. In protracted discussions with the Department of Human Resources they have offered the following options: a) a series of incremental adjustments to improve pay ranges (in progress), b) development of a new system that would require a ballot measure to amend civil service, and c) creation of a separate authority of the Department.

Regardless of the mechanism, if we are to improve the efficiency and quality of care, we must have the ability to vary physician pay based on the quantity and quality of work produced. The misalignment of incentives is at the very root of many of the problems at King/Drew Medical Center and across the Department.

8. *DHS Program Redesign*

In its System Redesign, the Department discussed the concept of program consolidation across facilities. Once the budget stabilized in early 2003, a program consolidation evaluation was initiated, using Neonatal Intensive Care Units (NICUs) as the pilot. Based on that analysis, the Department is moving forward with the consolidation and regionalization of neonatal intensive care services in its hospitals.

The analysis of the NICUs also served to emphasize the complex intertwining of clinical and educational programs in DHS hospitals. The reconfiguration of clinical or training programs at King/Drew Medical Center will affect all DHS hospitals. To that end, the Department has been meeting with UCLA and USC about enhancing the collaboration and integration of the training programs across the four DHS academic hospitals.

There are a number of other clinical areas that lend themselves to the reconfiguration of clinical and academic programs, such as Pathology, Radiology, Dermatology, Obstetrics-Gynecology, and Neurosurgery, which the Department is planning to examine more closely. Analysis and, to the extent indicated, realignment of these clinical and training programs will occur on a longer timeline. It is possible that the management of some programs may be changed or some programs may be consolidated with others, but the final configuration or model cannot be determined at this time.

Conclusion

The Department will continue its efforts to strengthen the management of the clinical, operational, and academic programs at King/Drew Medical Center and will keep you apprised of these efforts. As noted above, in order to facilitate some of these changes, the Department is seeking the Board's approval of the following recommendations:

- Authorize the Department to notify Drew University of the County's intent to terminate the affiliation agreement effective September 1, 2004 and instruct the Department to renegotiate the terms and conditions of the affiliation agreement and submit to the Board for its consideration a renegotiated agreement prior to September 1, 2004.

- Authorize the Department to take the necessary administrative steps to facilitate the consolidation or restructuring of clinical services at King/Drew Medical Center.

- Delegate authority to the Department to amend the current agreements with nurse registry agencies to establish rates that are consistent with those paid in the community for critical care, clinic, emergency room, surgical technologists, and hemodialysis nurses and nursing attendants, and to negotiate and execute agreements with any additional nurse registries that are willing to agree to the County's terms and conditions.

Please let me know if you have any questions.

TLG:ak

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

Task Force on Graduate Medical Education

Los Angeles County Department of Health Services
Charles R. Drew University of Medicine and Science

Findings and Recommendations

The mission of the Charles R. Drew University of Medicine and Science is to conduct education and research in the context of community service in order to train physicians and allied health professionals to provide care with excellence and compassion, especially to underserved populations.

The Task Force wishes to emphasize the importance and continuing relevance of the mission of Charles R. Drew University of Medicine and Science (Drew) in training minority physicians who choose to provide care to underserved populations. This mission is enhanced through its partnership with LA County Department of Health Services (DHS), whose mission is to provide the medically indigent with appropriate access to health services at the community level. This partnership between Drew and DHS comes together in the King/Drew Medical Center (KDMC) where healthcare is provided and where clinical teaching occurs. KDMC's record of success in achieving its mission is not duplicated elsewhere and represents a critical contribution to Los Angeles County and the nation.

For each of the past 30 years, about 300 post-graduate physicians (interns and residents), 24 medical students, 250 allied health professionals, and 8,000 physicians in practice have received training at King/Drew Medical Center (KDMC). In a statewide survey of graduating resident physicians in California, Drew students were the most likely to plan to practice in an inner city. In addition, the Drew College of Allied Health graduate survey conducted each year revealed that 95-97% of its graduates serve low income, medically underserved, or minority communities. Other studies show that Drew trainees follow through on these plans. Using data from minority graduates from 1989 – 1999, 54% of KDMC graduates continued to practice in low-income and minority populations, as compared to 36% of UCLA minority graduates. It is clear that the graduate medical training programs at KDMC make a major contribution to the enormous healthcare needs (see Addendum III) of the population of Service Planning Area 6 (SPA 6) and other underserved areas by graduating physicians who wish to serve in these areas.

However, Drew's current method for carrying out this vital role is seriously threatened, by a variety of circumstances both outside and within the control of those involved. The University now sits at a crossroads. The Task Force hopes that the guidance offered herein will be the broad outline of a road map that will steer the organization to ever-greater accomplishments in this vital mission.

The KDMC, with the proper support and partnership with other DHS facilities, the University of California System, USC, and others, is uniquely suited to take on some of the nation's most significant challenges in medical services delivery and post-graduate medical education. These challenges include reducing disparities in health, implementing the new NIH road map for reducing the time it takes to turn new knowledge into tangible benefits for patient care, and the challenge of providing care and public health to a multicultural population. Such a partnership could develop a national model for multicultural public health and medical care and for the

elimination of disparities in health. Such a transformation must be combined with a commitment to a culture of accountability at KDMC in order to attract funding and to demonstrate successful outcomes in residency training and quality patient care.

Overall Recommendation:

It is imperative to preserve King/Drew Medical Center while significantly upgrading the culture of accountability and integrity of oversight of its teaching programs. An opportunity for partnership with the University of California and other programs within the Los Angeles County system exists that can allow KDMC to respond to national goals relating to eliminating disparities in health as set forth by Healthy People 2010. The quality of patient care must be paramount in all programs.

Specific Recommendations:

1) **Partnership**

There has been no working partnership between DHS (as represented by King hospital administration) and Drew in carrying out residency training programs at KDMC. When comparing KDMC to the LAC+USC and Harbor/UCLA Medical Centers, this lack of a working partnership was a major difference. Each of the other entities felt that they were working together to oversee their residency training programs.

Recommendations:

We recommend that the DHS Director, the Chair of the Drew Board, and the President of Drew must commit and sustain an effort to correct this absence of partnership and communication, including the use of consultants with a strong track record in this type of situation. In addition, Ombudsman roles should be considered for KDMC, DHS and Drew to foster a culture of accountability and meet aggressive timelines for advancing problems up the chain of command [see Addendum II].

2) **Residency Programs**

The survival of residency training at KDMC is threatened by the loss of accreditation of two programs, the proposed withdrawal of another program, the probationary status of others and the institution's "Unfavorable" status. Equally threatening to residency training at KDMC is the drop in patient census and the loss of confidence by the community in the quality of care delivered at KDMC. Low patient census makes it difficult to support residency programs. It is not possible to sustain 18 residency training programs with an inpatient census of just over 200. Likewise, the damage done to residents who will be unable to complete their training at KDMC is inestimable. This will make it very difficult to attract residents who have other choices for their training.

At the Drew Board of Trustees meeting on December 18, Dr. Gerald Levey (Dean of the School of Medicine and Provost for Health Sciences at UCLA) described an opportunity to construct a mutually beneficial model that would include linked partnerships with training programs at other County hospitals. However, he stressed that before any

structural changes in residency programs are made, fundamental changes at KDMC must occur – including the correction of hospital management issues, addressing the falling census, and creating centers of excellence among the County hospitals similar to those discussed in DHS planning documents. Dr. Levey said that UCLA could participate in collaborative and advisory roles to determine how these partnerships can happen.

Recommendations:

The Task Force recommends a major overhaul of residency training including the development of an alliance with the University of California system and/or USC to assure that all residents have access to an integrated system of training of the highest quality within the LA County hospital system while preserving the KDMC mission and assuring the highest quality of patient care. This alliance could offer increased research opportunities for all partners.

This major overhaul should include a critical review of every training program at KDMC. Programs that are not sustainable should be discontinued as independent programs before they receive unfavorable review by accrediting agencies. These programs could become satellites of other programs or affiliates with other residency programs.

The Task Force emphasizes the need for and supports the changes in infrastructure and leadership that are in process within the hospital.

3) **Board of Trustees**

The Board of Trustees of Drew has failed to hold the leadership and administration of Drew accountable for the quality of programs and the performance of Drew faculty relative to the quality of patient care, teaching and learning.

The Board has also failed to hold itself accountable as evidenced by the lack of demonstrated commitment to regularly infuse the Board with new ideas, the lack of substantive fund raising to assure the long-term viability of the University, and the failure to attract sufficient members who could contribute in the area of academic excellence.

Recommendations:

The Drew Board must commit to self-reformation and accountability including a system to assure the regular infusion of new members and the targeting of new members who can contribute most to the long-term viability of Drew, financially, academically, and in the delivery of quality patient care.

Partnership should be demonstrated by adding representatives recommended by the DHS and the University of California system as full members (not ex-officio) of the Board.

Over the next six months, with the assistance of consultants, take steps to strengthen the oversight of patient care, the quality of teaching and learning, and the long term financial stability of Drew.

4) **Leadership of Drew**

The leadership (President) of Drew has not been accountable to the Board in terms of regularly reporting and alerting the Board to issues that threaten the viability of the University and its relationship with the County and State. The major agenda items of any Board meeting should be the President's Report and with rare exception, the President should be there in person to present it and respond to Board inquiry about it.

The President of Drew has lost the confidence of many on the Board, the faculty, and the surrounding community, including the Community Advisory Board to the President.

The President and other leadership of Drew have allowed the evolution and continuation of the present crisis regarding residency training, and have not responded with the sense of urgency that the situation demands. Despite early promises, the President has not yet proposed any plan or response to the previous visit of the Task Force.

Recommendation:

> The leadership of the President at Drew is critical to a successful response to the present crisis, as well as issues that have evolved over time, and to the future needs of Drew. The task force recommends a positive leadership transition at Drew.

5) **Physician Practice Plan**

There is no evidence of a functional faculty practice plan at the KDMC despite many attempts to implement one. Such a plan, however, is critical to a system of accountability for full-time clinical faculty. Both UCLA and USC have faculty practice plans. These are expedited by the existence of private facilities in the areas close to the County hospitals where private patients are treated by faculty.

The SPA 6 region in which KDMC is located is a very poor, low socio-economic area and is not supportive of private practice. Thus, KDMC faculty often sees and admits patients outside SPA 6 without a faculty practice plan to assure accountability to Drew.

Recommendation:

> The Drew Board and administration must develop a KDMC faculty practice plan or other mechanism to enhance recruitment and retention of qualified faculty, enforce accountability, and ensure that the mission of KDMC and community health care needs are the priorities of Drew faculty.

6) **Multicultural Health**

Dramatic change has taken place in the community surrounding KDMC. SPA 6 has experienced a shift in population demographics from an 80% African-American population base in the 1970s to a greater than 60% Latino representation today. Even though the Task Force did not have extensive interaction with persons from the Latino

community, it was our observation that the Institution has not incorporated a cultural change to match its own current environment.

The Chair of the Task Force has had the opportunity to talk with the President of The California Endowment (TCE) concerning the findings and recommendations. These discussions focused on four potential areas with national implications for the development of a model of solutions:

The questions:

I) How do we maintain quality healthcare and quality teaching programs in public hospitals/facilities serving predominantly poor communities, particularly those with dramatically changing racial/ethnic demographics such as those in SPA 6?

II) What is the role of partnership between historically Black academic health centers and predominantly White academic health centers in cultural competency programs, multi-cultural programs and the elimination of disparities in health?

III) How can a partnership between a predominantly White research intensive institution and a predominantly Black low research-intensive institution function to implement the NIH road map that focuses on moving from discovery to delivery of the best medical findings and technology to communities?

IV) How do we create a culture of accountability in an environment where accountability has been very low and where there is an environment of poverty and often hopelessness similar to that found in some other major public hospitals?

The President of The California Endowment expressed interest on the part of TCE to support efforts to make major changes at KDMC, including support of a transitional management team and development of KDMC as a center of excellence for multi-cultural public health and medicine. However, TCE would need to be confident that there is a clear plan and firm commitment to change.

Recommendations:

The Task Force recommends that Drew and DHS work together to develop a comprehensive plan to establish a center of excellence in multicultural health accompanied by a strategy for assuring accountability for quality patient care and residency training.

Drew should initiate a planning process, in conjunction with the community, the County and the University of California, to develop a Center of Excellence in Multicultural Medicine and Public Health and for the Elimination of Disparities in Health among Different Racial and Ethnic Groups.

Addenda

Addendum I: Specific Board of Supervisors' Questions and Responses:

a. The County's responsibility and obligation as a teaching hospital and the implications for patient care delivery:

The County has two major responsibilities or obligations as a teaching hospital:

- To maintain an environment of excellence in patient care with all the necessary support systems.
- To develop and maintain, through partnership or otherwise, an optimal environment for teaching, learning and other scholarly activities in order to prepare physicians and others for the future.

While this is done through partnership, the relationship must be one in which the two entities are wedded in their commitment to excellence in patient care and teaching – speaking with one voice about the need for accountability of all involved.

b. Review models utilized in other teaching hospitals with accreditation problems.

Most teaching hospitals at some point in their development or history will have some accreditation challenges. Rarely, however, will a teaching hospital have the number of accreditation problems experienced by the KDMC.

Perhaps the model most relevant to the situation at KDMC is the Meharry-Vanderbilt Alliance. After years of separation, distrust and significant accreditation problems at Meharry Medical College (MMC), which had been excluded from publicly funded facilities for most of its history, the merger of Meharry Hubbard Hospital (private) and Nashville General Hospital (public) created a unique opportunity for partnership between Meharry and Vanderbilt. The Meharry Vanderbilt Alliance builds on the unique strengths of each institution to coordinate quality patient care, teaching/learning and research. Students and residents move easily between the two institutions as needs demand.

Although residencies are separate, each institution's programs are strengthened by the Alliance. If a specialty area is not in place at Meharry but is at Vanderbilt University Medical Center (VUMC), students/residents are able to plan rotations accordingly with faculty cooperation. Likewise, if MMC has an experience not found at VUMC, students and residents rotate accordingly with faculty cooperation. Joint research efforts are attracting funds and targeting disparities in health.

UCLA has collaborated with Drew in their undergraduate medical education program and as a result hundreds of underrepresented minority physicians have been educated. UCLA could not have done this without Drew, and vice versa. A similar collaboration at the residency level could protect the independence of Drew while enhancing its partnership with UCLA or similar institutions within or outside the University of California system.

c. Evaluation of the physician private practice plan arrangements that exist at King/Drew and the other County hospitals and how the King/Drew practice plan can be enhanced to improve the recruitment and retention of qualified medical staff to ensure that the community's health care needs are met.

[Please refer to Recommendation #5 above.]

d. The academic content and commitment to the training program by the faculty and the Medical School.

[Please refer to Recommendations #2 & #6 above.]

e. Evaluate ways to strengthen the recruitment and retention of strong clinical and academic faculty.

Improve the overall operations of the hospital and the medical school. Expand appointments for patient care, teaching, and research by developing a broader partnership with the University of California system and/or USC.

Addendum II: Ombudsman

Ombudsman roled could be established along with aggressive and strict deadlines for solving the problems that threaten the viability of the organization. Timelines would assure that management attention at the highest level is focused on solving major problems within a defined period of time and according to a defined protocol.

This concept has been used effectively by companies and governments needing communication mechanisms to assure that serious problems are addressed and resolved in a timely manner.

The benefits of such a system are obvious. The problem-solving process is expedited; expectations are clearly understood. Another benefit is documentation of patterns of problems in organizational structure.

A detailed example of such a mechanism is available on the DHS website (http://www.lacdhs.org/ then go to Department Communications section and click on the link to Task Force on Graduate Medical Education at KDMC).

Addendum III: SPA 6 Characteristics

Rates of poverty and uninsurance among Los Angeles County residents are extremely high. Overall, 42% of residents live below 200% of the Federal Poverty Level (FPL), or under $37,000 per year for a family of four. Thirty one percent of adults ages 18-64 and 19% of children have no health insurance. However, rates vary widely across different areas of the County.

King/Drew Medical Center is located in the South Service Planning Area (SPA 6), which has the highest rate of poverty in the County, with nearly three-fourths (74%) of the population living below 200% FPL. SPA 6 also has the highest rates of uninsurance, with nearly half (47%) of non-elderly adults and 28% of children having no health insurance. Nearly one million (965,000) people live within a 5-mile radius of King/Drew. Of these, 65% are living below 200% FPL, and 39% are uninsured.

Task Force on Graduate Medical Education at King/Drew Medical Center

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Task Force on Graduate Medical Education at King/Drew Medical Center

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